Effect of an Investigational Vaccine for Preventing *Staphylococcus aureus* Infections After Cardiotoracic Surgery
A Randomized Trial

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**Infections with *Staphylococcus aureus* following median sternotomy cause substantial morbidity and mortality.**

A safe vaccine that provides protection against a majority of *S aureus* strains during the postoperative period would address an important unmet medical need.

A novel vaccine candidate (V710; Merck Sharp & Dohme Corp) containing the highly conserved *S aureus* 0657nI iron surface determinant B (IsdB) was protective in animal challenge models and immunogenic within 14 days after a single dose of either an adjuvanted or nonadjuvanted formulation in healthy volunteers. Antibody response to V710 was similar in younger and older participants.

**Importance** Infections due to *Staphylococcus aureus* are serious complications of cardiothoracic surgery. A novel vaccine candidate (V710) containing the highly conserved *S aureus* iron surface determinant B is immunogenic and generally well tolerated in volunteers.

**Objective** To evaluate the efficacy and safety of preoperative vaccination in preventing serious postoperative *S aureus* infection in patients undergoing cardiothoracic surgery.

**Design, Setting, and Participants** Double-blind, randomized, event-driven trial conducted between December 2007 and August 2011 among 8031 patients aged 18 years or older who were scheduled for full median sternotomy within 14 to 60 days of vaccination at 165 sites in 26 countries.

**Intervention** Participants were randomly assigned to receive a single 0.5-mL intramuscular injection of either V710 vaccine, 60 μg (n = 4015), or placebo (n = 4016).

**Main Outcome Measures** The primary efficacy end point was prevention of *S aureus* bacteremia and/or deep sternal wound infection (including mediastinitis) through postoperative day 90. Secondary end points included all *S aureus* surgical site and invasive infections through postoperative day 90. Three interim analyses with futility assessments were planned.

**Results** The independent data monitoring committee recommended termination of the study after the second interim analysis because of safety concerns and low efficacy. At the end of the study, the V710 vaccine was not significantly more efficacious than placebo in preventing either the primary end points (22/3528 V710 vaccine recipients [2.6 per 100 person-years] vs 27/3517 placebo recipients [2.6 per 100 person-years]; relative risk, 0.81; 95% CI, 0.44-1.48; P = .58) or secondary end points despite eliciting robust antibody responses. Compared with placebo, the V710 vaccine was associated with more adverse experiences during the first 14 days after vaccination (1219/3958 vaccine recipients [30.8%; 95% CI, 29.4%-32.3%] and 866/3967 placebo recipients [21.8%; 95% CI, 20.6%-23.1%], including 797 [20.1%; 95% CI, 18.9%-21.4%] and 378 [9.5%; 95% CI, 8.6%-10.5%] with injection site reactions and 66 [1.7%; 95% CI, 1.3%-2.1%] and 51 [1.3%; 95% CI, 1.0%-1.7%] with serious adverse events, respectively) and a significantly higher rate of multibacterial failure during the entire study (31 vs 17 events; 0.9 [95% CI, 0.6-1.2] vs 0.5 [95% CI, 0.3-0.8] events per 100 person-years; difference, 18.8 [95% CI, 8.0-34.1] per 100 person-years).

**Conclusions and Relevance** Among patients undergoing cardiothoracic surgery with median sternotomy, the use of a vaccine against *S aureus* compared with placebo did not reduce the rate of serious postoperative *S aureus* infections and was associated with increased mortality among patients who developed *S aureus* infections. These findings do not support the use of the V710 vaccine for patients undergoing surgical interventions.

**Trial Registration** clinicaltrials.gov Identifier: NCT00518687

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Elevated antibody responses persisted for at least 1 year after vaccination in most patients. The immunogenicity and tolerability of a lyophilized V710 formulation were generally similar to the properties of the original liquid formulation.

The current phase 2b/3 study was initiated to evaluate the efficacy and safety of preoperative vaccination with nonadjuvanted lyophilized V710 in preventing serious S aureus infections in patients about to undergo a median sternotomy for cardiothoracic surgery.

METHODS

Objectives

The primary efficacy objective was to demonstrate whether a single dose of V710 vaccine administered between 14 and 60 days prior to cardiothoracic surgery (involving a full median sternotomy) would reduce the proportion of adult patients with postoperative S aureus bacteremia and/or S aureus deep sternal wound infections through postoperative day 90 by at least 20% relative to placebo. Secondary efficacy objectives included demonstrating a reduction in the proportion of patients who developed any invasive or surgical site infection with S aureus through postoperative day 90. The primary safety objective was to evaluate the adverse event profile of a single dose of V710 vaccine administered preoperatively to patients awaiting cardiothoracic surgery. Immunogenicity was also assessed.

Study Design

A sequential-design, multicenter, randomized, double-blind, placebo-controlled trial was conducted internationally to evaluate the safety, efficacy, and immunogenicity of a 60-μg dose of V710 vaccine in patients aged 18 years or older scheduled for cardiothoracic surgery involving a full median sternotomy within 14 to 60 days following vaccination. The protocol was approved by the institutional review boards or ethical review committees at each site and executed in accordance with Good Clinical Practice guidelines. Patients were excluded if pregnant or breastfeeding, febrile (≥38.0°C [100.4°F]) in the previous 48 hours, immunocompromised (including but not limited to human immunodeficiency virus infection or immunosuppressive therapies), unstable, or recently immunized with any other vaccine (except for pneumococcal or influenza vaccines, which were allowed at least 7 days prior to or 15 days after study vaccination). Patients with cirrhosis, bleeding diathesis, renal failure requiring dialysis, or a history of injecting recreational drugs in the last 5 years were also excluded. At screening, specific preoperative variables were assessed to calculate a Society of Thoracic Surgeons score for the risk of major infections following cardiothoracic surgery with higher scores representing greater risk. Eligible patients provided written informed consent before any study procedures took place.

The V710 vaccine was provided as a lyophilized formulation without adjuvant stored at 2°C to 8°C (35.6°F to 46.4°F). The 0.45% saline diluent for V710 reconstitution and the placebo solution were kept at room temperature. The vaccine was to be reconstituted immediately before use, resulting in a clear, colorless to slightly yellow liquid, and administered by an unblinded pharmacist or study coordinator not otherwise involved in the patient’s subsequent care.

Participants were randomized in a 1:1 ratio (FIGURE) by site using an interactive voice response system to receive a single 0.5-mL injection of either 60 μg of V710 vaccine or 0.9% saline placebo in the deltoid (or thigh) muscle at the time of enrollment. Patients were monitored for evidence of immediate hypersensitivity reactions for 30 minutes after vaccination. The total time in the study for each patient was to be 14 to 60 days from vaccination to cardiothoracic surgery and another 360 days postoperatively; after termination of enrollment, patients still in the study were followed up for at least 90 days after vaccination. Study patients were mandated to receive preoperative antibiotic prophylaxis in addition to other customary preoperative and perioperative measures according to the local standard of care. The protocol offered nonbinding recommendations regarding selection, timing, and duration of prophylactic antibiotics. An independent data monitoring committee reviewed safety data on an ongoing basis and in conjunction with the predefined interim efficacy analyses.

Case Definitions and Adjudication Process

All efficacy end points were assessed through postoperative day 90 and adjudicated by an independent adjudication committee blinded to treatment group using the Centers for Disease Control and Prevention’s definitions for nosocomial infections. For the primary end points, bloodstream infection was defined as at least 1 positive blood culture for S aureus (regardless of the presence of clinical symptoms) and deep sternal wound infection was defined as postoperative mediastinitis or a surgical site infection involving the sternum or deeper myofascial tissue planes. The secondary efficacy end points were invasive S aureus infections (including bacteremia or any deep-seated infection) and superficial or deep surgical site infections (including the sternotomy, vascular harvest, and chest tube sites).

Statistical Analysis

The study was designed to detect at least a 20% reduction in the number of cases based on the prespecified combined end point of S aureus bacteremia and/or S aureus deep sternal wound infections through postoperative day 90 in V710 recipients compared with placebo recipients (ie, vaccine efficacy >20%). All reported adverse events irrespective of intensity or causality were tabulated for the 14-day period immediately following vaccination; selected serious adverse events continued to be collected for the entire 360-day postoperative length of the study. Patients were
handled as randomized for the primary efficacy analysis and as treated for the safety analysis.

The trial was event-driven, using the number of \textit{S} \textit{aureus} cases rather than number of enrolled patients for measuring trial progress and defining when the trial was complete. Total enrollment was estimated from the expected number of accumulated cases of \textit{S} \textit{aureus} bacteremia and/or \textit{S} \textit{aureus} deep sternal wound infections. A group-sequential design with 4 distinct stages (at 24, 48, 77, and 107 primary end point events) was used in the study such that after each threshold of primary end point events was reached, an analysis of futility and/or efficacy was conducted. Group-sequential methods\textsuperscript{14} using exact methods for binomial data (which adjusted for the predefined success and futility stopping rules at each stage) were used to calculate the exact power, type I error rate, and confidence intervals for efficacy. Stopping rules for futility were chosen to ensure that the probability of moving forward with a nonefficacious vaccine would be low while controlling the 1-sided type I error rate at 2.5%. Additionally, the stopping rules for success were selected such that if they were met, the resulting lower limit of the con-

\textbf{Figure. Participant Flow}

8143 Patients screened for study eligibility

112 Excluded
52 Failed screening
45 Patients withdrew
12 Study termination by sponsor
1 Protocol violation
1 Unknown

8031 Patients randomized

4015 Patients randomized to receive V710 vaccine

10 Patients excluded for questionable clinical practices at a single site

4005 Evaluable patients randomized to V710 vaccine group
3981 Received V710 vaccine as randomized
24 Did not receive V710 vaccine
14 Patients withdrew
4 Protocol violation
3 Physician decision
2 Progressive disease
1 Adverse event

1413 Discontinued study
930 Study termination by sponsor
200 Adverse events
144 Lost to follow-up
96 Patients withdrew
39 Physician decision
4 Protocol violations

2568 Completed study

3528 Included in primary modified ITT efficacy analysis
477 Excluded\textsuperscript{a}
254 Cardiothoracic surgery <14 d or >60 d after vaccination
166 No cardiothoracic surgery
34 Had cardiothoracic surgery but no full median sternotomy
24 Did not receive V710 vaccine
2 Had invasive \textit{Staphylococcus aureus} infection after vaccination but prior to surgery

4016 Patients randomized to receive placebo

11 Patients excluded for questionable clinical practices at a single site

4005 Evaluable patients randomized to placebo group
3982 Received placebo as randomized
23 Did not receive placebo
12 Patients withdrew
6 Protocol violation
5 Physician decision

2585 Completed study

3517 Included in primary modified ITT efficacy analysis
488 Excluded\textsuperscript{a}
290 Cardiothoracic surgery <14 d or >60 d after vaccination
150 No cardiothoracic surgery
25 Had cardiothoracic surgery but no full median sternotomy
23 Did not receive placebo
2 Had invasive \textit{Staphylococcus aureus} infection after vaccination but prior to surgery

Participants who discontinued the study could have discontinued at any of the following points: (1) following randomization but prior to vaccination; (2) following vaccination but prior to inclusion in the primary modified intention-to-treat (ITT) efficacy population; or (3) following inclusion in the primary modified ITT efficacy population but prior to completion or termination of the study. The predominant reason for not completing the study was the early termination of the trial, which accounted for 1848 (65\%) of the total 2857 patient discontinuations.

\textsuperscript{a}Patients may have been excluded from the primary modified ITT efficacy population for more than 1 reason but are included in the total only once.
Efficacy Analyses
Study efficacy results were based on a modified intention-to-treat (ITT) approach. Vaccine efficacy was defined by protocol as the relative risk reduction of an end point in vaccine recipients compared with the placebo group. The primary efficacy analysis was conducted in the primary modified ITT population, prespecified as vaccinated patients who underwent full median sternotomy between day 14 and day 60 after vaccination and who did not develop a serious preoperative 
S. aureus infection. The primary modified ITT population was denoted as the full analysis set in the protocol. The primary efficacy analysis was supported by a secondary modified ITT analysis and a per-protocol analysis. A secondary modified ITT population included vaccinated patients who subsequently underwent cardiothoracic surgery irrespective of the type of surgical procedure or timing relative to vaccination. Patients who developed serious preoperative 
S. aureus infections were retained in the secondary modified ITT population. The per-protocol population included vaccinated patients who subsequently underwent full median sternotomy between day 14 and day 60 after vaccination with neither serious preoperative 
S. aureus infections nor major protocol violations. Cross-treated patients were analyzed based on the vaccination group to which they were randomized in the primary and secondary modified ITT populations and based on what they actually received in the per-protocol population.

To supplement the estimates of vaccine efficacy stipulated in the protocol and required by regulatory agencies (which were based on the case split without regard to duration of follow-up), relative risks (which accounted for both the number of patients and length of follow-up time) were calculated for the key primary efficacy results.

Safety Analyses
All vaccinated patients with follow-up data were included in the adverse experiences summaries as treated. Adverse experiences reported by the site investigator as possibly, probably, or definitely vaccine-related were tallied as vaccine-related. Injection site reactions and oral temperatures were actively monitored for 5 days after vaccination. All adverse experiences in the 14 days immediately after vaccination were captured using a patient vaccine report card. Serious adverse experiences considered to be vaccine-related, associated with 
S. aureus infection, and/or resulting in death were to be reported throughout the entire study. Subsequent to recognition of a safety signal, the incidence of multiorgan failure was retrospectively assessed irrespective of causality or timing. Diagnoses of “multiorgan failure” were accepted verbatim as an adverse event term reported by the site investigators; no definitions or criteria were imposed per protocol because this complication was not anticipated as an issue a priori. Extensive post hoc exploratory analyses were performed to investigate safety concerns. After the decision to terminate the study was made, all vaccinated patients still in the study were to be followed up at least until postvaccination day 90. Due to the potential for differing follow-up times for individual patients, the overall adverse event rate was to be expressed as the number of patients with adverse experiences per 100 person-years of follow-up. Patients developing multiple adverse experiences were counted only once in any given category.

Prior to the early study termination, the primary safety end point had been specified per protocol as the incidence of vaccine-related serious adverse experiences developing at any time after vaccination through postoperative day 180. The point estimate with its corresponding 2-tailed 95% confidence interval for the risk difference between the V710 and placebo groups of developing a vaccine-related serious adverse experience was to be calculated using the method of Miettinen and Nurminen15 for analysis of Poisson rates accounting for the potential differential follow-up time. Frequencies were also
computed for adverse experiences occurring during the 14-day postvaccination period.

**Immunogenicity Analyses**

Blood samples were to be collected from all patients just before vaccination, at the time of hospitalization for surgery (14 to 60 days after vaccination), and on postoperative days 45 and 90 for exploratory immunogenicity analyses. In a preselected subset of patients, additional specimens were to be obtained on postoperative days 180, 270, and 360 as well. A direct binding assay was developed for the detection of total IgG antibodies to the iron surface determinant of *S aureus* using a Lumiplex platform. Opsonophagocytic activity was assessed with an investigational assay by the uptake of fluorescently labeled *S aureus* by a human granulocytic cell line in the presence or absence of patient serum, comparing postvaccination to preimmune serum samples.

**RESULTS**

**Patient Accounting and Baseline Characteristics**

The study was conducted from December 12, 2007, to August 19, 2011, at 165 sites in 26 countries on 5 continents. No concerns were raised by the data monitoring committee following the initial interim analysis in January 2010. Following the second interim analysis on April 8, 2011, the data monitoring committee recommended suspension of enrollment and vaccination because of concerns about a possibly higher rate of mortality and multiorgan failure in V710 vaccine recipients than in placebo recipients, and the committee requested further analyses. On June 2, 2011, following review of the supplemental results, the data monitoring committee recommended permanently closing the study to enrollment because of continuing safety concerns coupled with the low probability of success. The sponsor followed the recommendations from the data monitoring committee.

When the database was locked on September 13, 2011, 7983 participants had been vaccinated (Figure). Because repeated audits had uncovered irregularities in clinical practices at 1 site, 21 patients from this site were excluded from all analyses before the data were unblinded. Five participants were inadvertently given the wrong injection based on the group to which they had been randomized. Two patients in each group experienced a serious preoperative *S aureus* infection leading to exclusion from the primary efficacy population; none of these 4 patients developed a postoperative *S aureus* infection. Approximately 64% of patients in each study group completed the 360-day safety follow-up. The predominant reason for patients discontinuing the study was the premature study termination by the sponsor in response to the recommendation of the data monitoring committee, accounting for 1848 (69%) of the total 2857 discontinuations.

Baseline characteristics of randomized patients were balanced across groups (Table 1). Vaccine and placebo recipients had similar metabolic characteristics, infection risk scores, *S aureus* colonization rates, and types of surgical procedure.

**Efficacy**

In the primary modified ITT analysis, V710 vaccine was not significantly more efficacious than placebo in preventing the prespecified combined end point (22 adjudicated cases in 3528 evaluable V710 recipients vs 27 adjudicated cases in 3517 evaluable placebo recipients; event rate, 2.6 [95% CI, 1.6-4.0] vs 3.2 [95% CI, 2.1-4.7] per 100 person-years, respectively), yielding a relative risk of 0.81 (95% CI, 0.44-1.48). There was no significant vaccine efficacy (18.5%; 95% CI, −48.6% to 55.8%) (Table 2). No significant differences in efficacy between the vaccine and placebo groups were observed at any point during the study (eFigure 1; available at http://www.jama.com). An additional adjudicated case of *S aureus* infection in a V710 vaccine recipient had been excluded from the primary analysis because it had been determined during a quality-assurance audit that the site might have used questionable clinical practices. Inclusion of this additional adjudicated case yielded a nonsignificant vaccine efficacy of 14.8% (95% CI, −54.3% to 53.3%). Two cases from each group were reported after termination of the trial and consequently not adjudicated. Counting all cases, overall vaccine efficacy with respect to the primary end point was also nonsignificant (13.8%; 95% CI, −52.5% to 51.6%).

In the secondary modified ITT analysis, estimates based on adjudicated cases ranged from 12.9% (95% CI, −50.8% to 50.0%) for preventing invasive *S aureus* infections to 29.3% (95% CI, −1.8% to 51.2%) for preventing *S aureus* surgical site infections. The lower number of *S aureus* surgical site infections was driven by fewer superficial lower extremity (usually saphenous vein) donor site infections (13 vs 36 in the V710 and placebo groups, respectively), without a meaningful between-group difference in the infection rate for sternal wounds. However, harvesting techniques, perioperative antibiotic prophylaxis, and other adjunctive measures were not controlled and varied among sites. Combining all end points, vaccine efficacy was 25.3% (95% CI, −3.4% to 46.2%) (eFigure 2).

In a post hoc analysis, estimates of vaccine efficacy were higher in preventing methicillin-susceptible *S aureus* (MSSA) than methicillin-resistant *S aureus* (MRSA) infections for the primary, secondary, and exploratory end points. Infection with MRSA occurred in 23 (34%; 95% CI, 23%-46%) of the 68 V710 vaccine recipients with *S aureus* infection and in 17 (19%; 95% CI, 11%-28%) of the 91 placebo recipients with *S aureus* infection in the primary efficacy population (P = .04). *Staphylococcus aureus* infections developed in 3.3% (95% CI, 2.1%-4.9%) and 5.5% (95% CI, 3.9%-7.6%) of nasal carriers compared with 1.6% (95% CI, 1.2%-2.2%) and 1.8% (95% CI, 1.4%-2.4%) of noncarriers in the V710 and placebo groups, respectively (P = .09).
All patients with reported multiorgan failure died. A full list of all serious adverse experiences in both V710 and placebo recipients is provided in the eTable.

Significantly more patients with postoperative *S aureus* infections died in the V710 vaccine group (15 deaths) than in the placebo group (4 deaths), yielding respective mortality rates of 23.0

**Table 1.** Selected Baseline Characteristics of Randomized Patients by Group

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>V710 Vaccine Group (n = 4005)</th>
<th>Placebo Group (n = 4005)</th>
<th>Total (n = 8010)</th>
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<tbody>
<tr>
<td><strong>Vaccinated</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Male</td>
<td>3981 (99)</td>
<td>3982 (99)</td>
<td>7963 (99)</td>
</tr>
<tr>
<td>Female</td>
<td>1328 (33)</td>
<td>1336 (33)</td>
<td>2664 (33)</td>
</tr>
<tr>
<td><strong>Self-identified race</strong></td>
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<td></td>
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<tr>
<td>White</td>
<td>3089 (77)</td>
<td>3062 (76)</td>
<td>6151 (77)</td>
</tr>
<tr>
<td>Black</td>
<td>71 (2)</td>
<td>77 (2)</td>
<td>148 (2)</td>
</tr>
<tr>
<td>Asian</td>
<td>521 (13)</td>
<td>543 (14)</td>
<td>1064 (13)</td>
</tr>
<tr>
<td>Multiracial</td>
<td>311 (8)</td>
<td>311 (8)</td>
<td>622 (8)</td>
</tr>
<tr>
<td>Other or unknown</td>
<td>13 (&lt;1)</td>
<td>12 (&lt;1)</td>
<td>25 (&lt;1)</td>
</tr>
<tr>
<td><strong>Self-reported ethnicity</strong></td>
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<td></td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>903 (23)</td>
<td>905 (23)</td>
<td>1808 (23)</td>
</tr>
<tr>
<td><strong>Region</strong></td>
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<td></td>
</tr>
<tr>
<td>Asia/Pacific (New Zealand)</td>
<td>1977 (49)</td>
<td>1975 (49)</td>
<td>3952 (49)</td>
</tr>
<tr>
<td>Europe (including Russia)</td>
<td>523 (13)</td>
<td>529 (13)</td>
<td>1052 (13)</td>
</tr>
<tr>
<td>Latin America</td>
<td>731 (18)</td>
<td>733 (18)</td>
<td>1464 (18)</td>
</tr>
<tr>
<td>United States</td>
<td>774 (19)</td>
<td>768 (19)</td>
<td>1542 (19)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Median (range), y</td>
<td>65 (18-91)</td>
<td>66 (19-93)</td>
<td>66 (18-93)</td>
</tr>
<tr>
<td>&gt;70 y</td>
<td>1332 (33)</td>
<td>1353 (34)</td>
<td>2685 (34)</td>
</tr>
<tr>
<td><strong>Underlying metabolic conditions</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>963 (24)</td>
<td>961 (24)</td>
<td>1924 (24)</td>
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<tr>
<td>BMI &gt;30</td>
<td>1108 (28)</td>
<td>1027 (26)</td>
<td>2135 (27)</td>
</tr>
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<td><strong>Society of Thoracic Surgeons infection risk score, median (range)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-2</td>
<td>6 (0-26)</td>
<td>6 (0-26)</td>
<td>12 (0-26)</td>
</tr>
<tr>
<td>&gt;2</td>
<td>738 (18)</td>
<td>714 (18)</td>
<td>1452 (18)</td>
</tr>
<tr>
<td><strong>Nasal colonization</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonized with any <em>Staphylococcus aureus</em></td>
<td>72 (2)</td>
<td>65 (2)</td>
<td>137 (2)</td>
</tr>
<tr>
<td>Colonized with MRSA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Underwent cardiothoracic surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full median sternotomy</td>
<td>3784 (94)</td>
<td>3807 (95)</td>
<td>7591 (95)</td>
</tr>
<tr>
<td>Any cardiothoracic procedure</td>
<td>3815 (95)</td>
<td>3832 (96)</td>
<td>7647 (96)</td>
</tr>
<tr>
<td>CABG surgery only</td>
<td>1193 (30)</td>
<td>1241 (31)</td>
<td>2434 (30)</td>
</tr>
<tr>
<td>Aortic valve</td>
<td>1037 (26)</td>
<td>991 (25)</td>
<td>2028 (25)</td>
</tr>
<tr>
<td>Mitral valve</td>
<td>496 (12)</td>
<td>484 (12)</td>
<td>980 (12)</td>
</tr>
<tr>
<td>Tricuspid valve</td>
<td>22 (1)</td>
<td>23 (1)</td>
<td>45 (1)</td>
</tr>
<tr>
<td>CABG surgery and valve</td>
<td>313 (8)</td>
<td>357 (9)</td>
<td>670 (8)</td>
</tr>
<tr>
<td>Other</td>
<td>754 (19)</td>
<td>736 (18)</td>
<td>1490 (19)</td>
</tr>
<tr>
<td><strong>Timing of operation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days after vaccination, median (IQR)</td>
<td>24 (18-37)</td>
<td>24 (18-36)</td>
<td>48 (18-37)</td>
</tr>
<tr>
<td>&lt;14</td>
<td>26 (1)</td>
<td>41 (1)</td>
<td>67 (1)</td>
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<tr>
<td>14-40</td>
<td>2983 (74)</td>
<td>2982 (74)</td>
<td>5965 (74)</td>
</tr>
<tr>
<td>41-60</td>
<td>578 (14)</td>
<td>560 (14)</td>
<td>1138 (14)</td>
</tr>
<tr>
<td>61-90</td>
<td>152 (4)</td>
<td>167 (4)</td>
<td>319 (4)</td>
</tr>
<tr>
<td>&gt;90</td>
<td>76 (2)</td>
<td>82 (2)</td>
<td>158 (2)</td>
</tr>
</tbody>
</table>

Abbreviations: BMI, body mass index (calculated as weight in kilograms divided by height in meters squared); CABG, coronary artery bypass graft; IQR, interquartile range; MRSA, methicillin-resistant *Staphylococcus aureus*.

Data are expressed as No. (%) of participants unless otherwise indicated. Denominators were not adjusted for missing data. The 21 patients randomized at the site with questionable clinical practices (n=10 to the V710 group and n=11 to the placebo group) have been excluded from this table and all analyses.

3. Adapted from Fowler et al.14

4. Corresponds to patients included in the secondary (modified intention-to-treat) analysis.
(95% CI, 12.9-37.9) and 4.2 (95% CI, 1.2-10.8) per 100 person-years (difference, 18.8 [95% CI, 8.0-34.1] per 100 person-years) (Table 4). In contrast to the placebo group (in which none of the 17 patients with MRSA infections died), the mortality rate in V710 recipients was numerically higher in patients infected with MRSA (8/24 [33%; 95% CI, 16%-55%]) than with MSSA (7/49 [14%; 95% CI, 6%-27%]). Preoperative antibody responses were comparable among V710 recipients with postoperative S aureus infection whether they survived or died. In the overall subgroup with staphylococcal infection, 5 deaths were attributed to multiorgan failure, all of which occurred in V710 recipients.

**Immunogenicity**

Preliminary characterization of the clinical isolates indicated that the isdB gene was highly conserved, with more than 95% homology. Anti-IsdB IgG titers at the time of surgery in V710 vaccine recipients were consistently greater than the prevaccination baseline levels, indicating that the vaccine was immunogenic (eFigure 3). Furthermore, the antibody titers after receipt of V710 vaccine were significantly higher than after receipt of placebo. Antibody responses in V710 recipients who developed primary S aureus infections were comparable with the titers achieved in V710 recipients who did not develop S aureus infection. Geometric mean anti-IsdB IgG levels peaked near postoperative day 45 and then slowly but steadily declined.

The V710 vaccine induced a significant, albeit modest and transient, increase in functional antibodies. The geometric mean increase in antibody titer with opsonophagocytic activity from baseline was 2.5-fold (95% CI, 2.2-2.8) in the subset of 299 V710 recipients evaluated 14 to 60 days after vaccination (just prior to surgery) and 1.9-fold (95% CI, 1.6-2.2) in the 94 V710 recipients evaluated at postoperative day 90, but had decreased to 1.2-fold (95% CI, 1.0-1.3) in the 84 V710 recipients evaluated on postoperative day 360. The corresponding percentages of evaluable V710 recipients achieving at least a 4-fold increase in opsonophago-

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**Table 2. Primary and Sensitivity Efficacy Analyses of the Composite Primary End Point**

<table>
<thead>
<tr>
<th>Prespecified Analyses</th>
<th>V710 Vaccine Group</th>
<th>Placebo Group</th>
<th>Vaccine Efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Secondary modified ITT analysis</strong>&lt;sup&gt;a&lt;/sup&gt; (vaccinated patients with any cardiothoracic procedure)</td>
<td>23</td>
<td>3815</td>
<td>903.6</td>
</tr>
<tr>
<td><strong>Primary modified ITT analysis</strong>&lt;sup&gt;a&lt;/sup&gt; (vaccinated patients with full median sternotomy on postvaccination day 14-60)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>22</td>
<td>3528</td>
<td>837.6</td>
</tr>
<tr>
<td><strong>Supportive per-protocol analysis</strong>&lt;sup&gt;a&lt;/sup&gt; (vaccinated patients with full median sternotomy on postvaccination day 14-60 without major protocol violations)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>19</td>
<td>3456</td>
<td>822.2</td>
</tr>
</tbody>
</table>

Abbreviations: ITT, intention-to-treat; S aureus, Staphylococcus aureus.

<sup>a</sup>The prespecified primary end points were postoperative S aureus bacteremia and/or S aureus deep sternal wound infections through postoperative day 90.

<sup>b</sup>Total efficacy follow-up time (years) from date of surgery to the first S aureus infection or the end of the protocol-stipulated efficacy window (90 days after surgery).

<sup>c</sup>The absolute rate of S aureus bacteremia or deep sternal wound infection per 100 person-years was (c/years) × 100, where c is the number of patients with S aureus bacteremia or deep sternal wound infection.

<sup>d</sup>Vaccine efficacy was calculated as (1 − cV710/cplacebo) × 100, where c is the number of patients with S aureus bacteremia or deep sternal wound infection, based on the number of cases in the V710 and placebo groups without regard to length of follow-up, as stipulated in the protocol and by regulatory agencies. To supplement the estimates of vaccine efficacy (which were based on the case split without regard to duration of follow-up), relative risks (which accounted for both the number of patients and length of follow-up time) were retrospectively computed for the key primary efficacy results. Because the length of follow-up was modestly different for the V710 and placebo groups, the relative risk reduction (1 − relative risk) closely approximates but does not exactly match the vaccine efficacy.

<sup>e</sup>Patients experiencing a serious preoperative S aureus infection were to be excluded from these analyses. There were 2 such cases in each group, but none of these 4 patients developed a subsequent postoperative S aureus event point during the study.
cystic antibody titer at these 3 points were 29% (95% CI, 24%-35%) at 14 to 60 days, 17% (95% CI, 10%-26%) at 90 days, and 4% (95% CI, 1%-10%) at 360 days. In contrast to the V710 group, the change in baseline geometric mean titer for evaluable placebo recipients was not significantly different from 1 (indicating no meaningful increase) at any of the 3 measurement points, and only 3 (1%; 95% CI, 0%-4%) of the 241 placebo recipients evaluated 14 to 60 days after vaccination had at least a 4-fold increase in titer.

**Table 3. Types and Frequencies of Adverse Experiences (AEs)**

<table>
<thead>
<tr>
<th>Frequency of preoperative AEs during the 14-d postvaccination period, No. (%) [95% CI] of vaccinated patients with safety follow-up</th>
<th>V710 Vaccine Group (n = 3958)</th>
<th>Placebo Group (n = 3967)</th>
<th>Between-Group Difference (95% CI)²</th>
</tr>
</thead>
<tbody>
<tr>
<td>With any AE</td>
<td>1219 (30.8) [29.4-32.3]</td>
<td>866 (21.8) [20.6-23.1]</td>
<td>9.0 (7.0 to 10.9)</td>
</tr>
<tr>
<td>With vaccine-related AE³</td>
<td>821 (20.7) [19.5-22.0]</td>
<td>437 (11.0) [10.1-12.0]</td>
<td>9.7 (8.1 to 11.3)</td>
</tr>
<tr>
<td>With febrile reaction⁴</td>
<td>17 (0.4) [0.3-0.7]</td>
<td>29 (0.7) [0.5-1.0]</td>
<td>ND</td>
</tr>
<tr>
<td>With vaccine-related febrile reaction AE⁵,⁶</td>
<td>6 (0.2) [0.1-0.3]</td>
<td>13 (0.3) [0.2-0.6]</td>
<td>ND</td>
</tr>
<tr>
<td>With injection site AE⁷</td>
<td>797 (20.1) [18.9-21.4]</td>
<td>378 (9.5) [8.6-10.5]</td>
<td>10.6 (9.1 to 12.2)</td>
</tr>
<tr>
<td>With vaccine-related injection site AE⁸,⁹</td>
<td>760 (19.2) [18.0-20.5]</td>
<td>360 (9.1) [8.2-10.0]</td>
<td>10.1 (8.6 to 11.7)</td>
</tr>
<tr>
<td>With non-injection site AE</td>
<td>673 (17.0) [15.8-18.2]</td>
<td>602 (15.2) [14.1-16.3]</td>
<td>1.8 (0.2 to 3.4)</td>
</tr>
<tr>
<td>With vaccine-related non-injection site AE¹⁰</td>
<td>122 (3.1) [2.6-3.7]</td>
<td>111 (2.8) [2.3-3.4]</td>
<td>0.3 (0.5 to 1.0)</td>
</tr>
<tr>
<td>With serious AE</td>
<td>66 (1.7) [1.3-2.1]</td>
<td>51 (1.3) [1.0-1.7]</td>
<td>0.4 (0.2 to 0.9)</td>
</tr>
<tr>
<td>With serious vaccine-related AE³</td>
<td>0 [0.0-0.1]</td>
<td>0 [0.0-0.1]</td>
<td>0.0 (0.1 to 0.1)</td>
</tr>
<tr>
<td>With non–injection site AE</td>
<td>673 (17.0) [15.8-18.2]</td>
<td>602 (15.2) [14.1-16.3]</td>
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<td>10.6 (9.1 to 12.2)</td>
</tr>
<tr>
<td>With serious AE</td>
<td>66 (1.7) [1.3-2.1]</td>
<td>51 (1.3) [1.0-1.7]</td>
<td>0.4 (0.2 to 0.9)</td>
</tr>
<tr>
<td>With serious vaccine-related AE³</td>
<td>0 [0.0-0.1]</td>
<td>0 [0.0-0.1]</td>
<td>0.0 (0.1 to 0.1)</td>
</tr>
<tr>
<td>With any cause</td>
<td>1219 (30.8) [29.4-32.3]</td>
<td>866 (21.8) [20.6-23.1]</td>
<td>9.0 (7.0 to 10.9)</td>
</tr>
<tr>
<td>Rate (%) [95% CI] per 100 person-years of AEs occurring anytime during the study⁴</td>
<td>11 (0.3) [0.1-0.5]</td>
<td>6 (0.2) [0.1-0.3]</td>
<td>0.1 (0.1 to 0.4)</td>
</tr>
</tbody>
</table>

**Table 4. Analysis of Mortality and Multorgan Failure in Patients With Postoperative Staphylococcus aureus Infections**

<table>
<thead>
<tr>
<th>No. of Events</th>
<th>Total Follow-up Person-Years⁵</th>
<th>Estimated Event Rate per 100 Person-Years [95% CI]</th>
<th>No. of Events</th>
<th>Total Follow-up Person-Years⁵</th>
<th>Estimated Event Rate per 100 Person-Years [95% CI]</th>
<th>Rate Difference, [95% CI] per 100 Person-Years [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with S aureus bacteremia or deep sternal wound infection</td>
<td>Total</td>
<td>MRSA</td>
<td>Total</td>
<td>MRSA</td>
<td>Total</td>
<td>MRSA</td>
</tr>
<tr>
<td>Who died</td>
<td>23</td>
<td>11</td>
<td>28</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who died</td>
<td>7</td>
<td>4</td>
<td>19.6</td>
<td>35.7 (14.4-73.6)</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Who died with multiorgan failure</td>
<td>3</td>
<td>2</td>
<td>20.2</td>
<td>14.9 (3.1-43.4)</td>
<td>0</td>
<td>25.9</td>
</tr>
<tr>
<td>Patients with any S aureus infection</td>
<td>Total</td>
<td>MRSA</td>
<td>Total</td>
<td>MRSA</td>
<td>Total</td>
<td>MRSA</td>
</tr>
<tr>
<td>Who died</td>
<td>73</td>
<td>24</td>
<td>96</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who died</td>
<td>15</td>
<td>8</td>
<td>65.2</td>
<td>23.0 (12.9-37.9)</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Who died with multiorgan failure</td>
<td>5</td>
<td>2</td>
<td>65.9</td>
<td>7.6 (2.5-17.7)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Comment**

The development of a safe and effective vaccine against serious *S aureus* infections in high-risk populations would represent a major step forward, but continues to present unresolved challenges.¹⁸-²⁰ *Staphylococcus aureus* vac-

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cine candidates to date have been designed to elicit production of opsonic antibodies, but humoral immunity may be inadequate to prevent S aureus infections.18-22 An earlier vaccine containing S aureus types 5 and 8 capsular polysaccharides conjugated to nontoxic recombinant Pseudomonas aeruginosa exotoxin A (StaphVAX, Nabi Biopharmaceuticals) appeared to confer limited short-term protection against S aureus bacteremia in patients undergoing hemodialysis for approximately 40 weeks after vaccination in a proof-of-concept study21; however, a larger clinical trial later failed to demonstrate any benefit.22

In our study of adult patients undergoing cardiothoracic surgery, preoperative vaccination with V710 did not significantly reduce the composite incidence of S aureus bacteremia and deep sternal wound infection. Because vaccination with V710 resulted in consistent humoral responses, the lack of efficacy was not simply due to failure to boost IgG levels against homologous IsdB. A numerical reduction in the number of end points in the vaccine group relative to the placebo group was seen during the early postoperative period when antibody titers were peaking, but these differences were not statistically significant. In a series of post hoc subgroup analyses uncorrected for multiple comparisons, vaccine efficacy was numerically higher against MSSA than MRSA infections, superficial than deep surgical site infections, and in baseline nasal S aureus carriers than in noncarriers, but the wide confidence intervals around these point estimates included zero. Overall mortality also did not significantly differ in the 2 groups. However, further analyses demonstrated that S aureus–infected V710 recipients were significantly more likely to die postoperatively than S aureus–infected placebo recipients. A higher mortality rate in infected V710 recipients relative to placebo recipients was evident among patients experiencing a primary end point (ie, bacteremia and/or deep sternal wound infection) as well as among patients developing any type of postoperative S aureus infection.

In the second planned interim analysis, multiorgan system failure in the postoperative period (as gauged by serious adverse event reporting) appeared to be associated with receipt of V710 vaccine. Since no protocol-prescribed criteria for multiorgan failure were available, the adverse event term could have been applied inconsistently at different study sites. Despite the post hoc nature of the many exploratory analyses, which were unadjusted for multiple comparisons, the consistency of the association between V710 and later development of multiorgan failure across multiple subgroups raises the possibility that the relationship may not simply be the result of chance alone.

A causal relationship linking receipt of V710 vaccine to higher rates of delayed multiorgan failure and mortality among S aureus–infected patients in this trial has not been established. MRSA infections, which have been associated with a higher mortality than MSSA surgical site infections, were more common in the V710 group than the placebo group and potentially could have contributed in part to the observed higher mortality among V710 recipients. However, a clear mechanism by which the anti-IsdB antibody response induced by preoperative receipt of V710 could have aggravated the outcome of postoperative staphylococcal infections in our patients, despite appearing safe and efficacious in the early clinical studies and preclinical models, remains to be determined. The paradoxical finding of worse outcomes after receipt of a vaccine has been previously encountered.28-32

The role of humoral immunity in protecting against S aureus is incompletely understood.33 For example, the presence of antibodies to the S aureus Panton-Valentine leukocidin has been associated with poor outcomes in a murine soft-tissue infection model. Opsonophagocytic antibodies induced by V710 (if not accompanied by bacterial killing) could theoretically permit intracellular survival of S aureus, potentially enhancing morbidity and mortality; however, the increase in opsonophagocytic activity observed after V710 administration was generally modest. Subsequent to termination of our study, the potential role of cell-mediated immunity in protection against S aureus infections has received increasing attention.

In conclusion, the use of the V710 vaccine against S aureus did not reduce the rate of serious postoperative S aureus infections compared with placebo and was associated with increased mortality among patients who developed S aureus infections. These findings do not support the use of the V710 vaccine for patients undergoing surgical interventions.
may own stock or stock options in the company. All authors have been investigators for Merck. Dr. Fowler reports that he was compensated by Merck for serving as chair of the V710 Scientific Advisory Committee; has received grant support from Merck, CereaRx, Pfizer, Novartis, Advanced Liquids Logics, Medimmune, and the National Institutes of Health; has been a paid consultant for Merck, Astellas, Cubist, CeresaRx, Durata, Pfizer, NovaDigm, Novartis, the Medicines Company, Bio-synech, Medimmune, Galderma, and Innomoc and has received honoraria from Merck, Astellas, Cubist, Pfizer, Theravance, and Novartis. Dr. Moreira reports that he has received research grants from Merck through his institution and honoraria from Merck for speaking engagements and board memberships. Dr. Moustafa reports consulting fees/honoraria and support for travel from Merck. Dr. Boucher reports that she was compensated by Merck for serving on the adjudication committee for this study, is the recipient of a National Institutes of Health grant to study catheter-related bloodstream infections, and has been a paid consultant for Merck, Basilea, Cubist, Durata, Johnson & Johnson, RBx, Targa/TMC, Wyeth/Pfizer, and Paratek. Dr. Corey reports that he has received grants from Theravance, the Medicines Company, and Innomic and has served as a consultant and/or advisor for Merck, AstraZeneca, Astellas, Cubist, Cubist Pharmaceuticals, CerezaRx/Forest Pharmaceuticals, PRA International, American Society for Microbiology, GlaxoSmithKline, Polymedix, Achaogen, TriaRx, RBx, Nabriva, Seachaid, Biocryst, Durata, and Gilead. Dr. Carmeli reports that he has been a paid consultant for Merck, AstraZeneca, Achaogen, Astrazeneca, Basilea, Intecell, Johnson & Johnson, RBx, and Polroteclogics. No other disclosures were reported.

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Disclaimer: The opinions expressed in this report represent the consensus of the authors and do not necessarily reflect the formal position of Merck or other institutions listed as author affiliations.


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